SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Discharge Planning in Integrated Care Settings

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Linda Ligenza, LCSW

Linda is a licensed clinical social worker and Clinical Services Director for the National Council for Behavioral Health. She provides guidance and technical assistance to SAMHSA and HRSA grantees on integrating primary care and behavioral health on behalf of the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). Linda's expertise in trauma and trauma-informed care further assists the CIHS audience to improve practices, policies, procedures, and outcomes

Ms. Ligenza has a background in clinical, administrative, and public policy work based on her 30 year career. She worked first with the New York State Office of Mental Health and subsequently with SAMHSA in the Traumatic Stress Services Branch of the Center for Mental Health Services.

Andrew Philip, PhD

Andrew is a clinical health psychologist and the Deputy Director for the SAMHSA-HRSA Center for Integrated Health Solutions. He has a clinical background as a psychologist in primary care, and has assisted with large-scale training and integration efforts in federal healthcare. Dr. Philip has experience integrating behavioral health within numerous medical settings including acute trauma and intensive care, burn, neurology, palliative care, psychiatry, infectious disease, and primary care. Dr. Philip has emphasized improving care for diverse groups such as LGBTQ and veteran populations. In his work at the National Council, Dr. Philip assists in driving local and national initiatives aimed at improving patient care and promoting innovation in the field of integrated health.

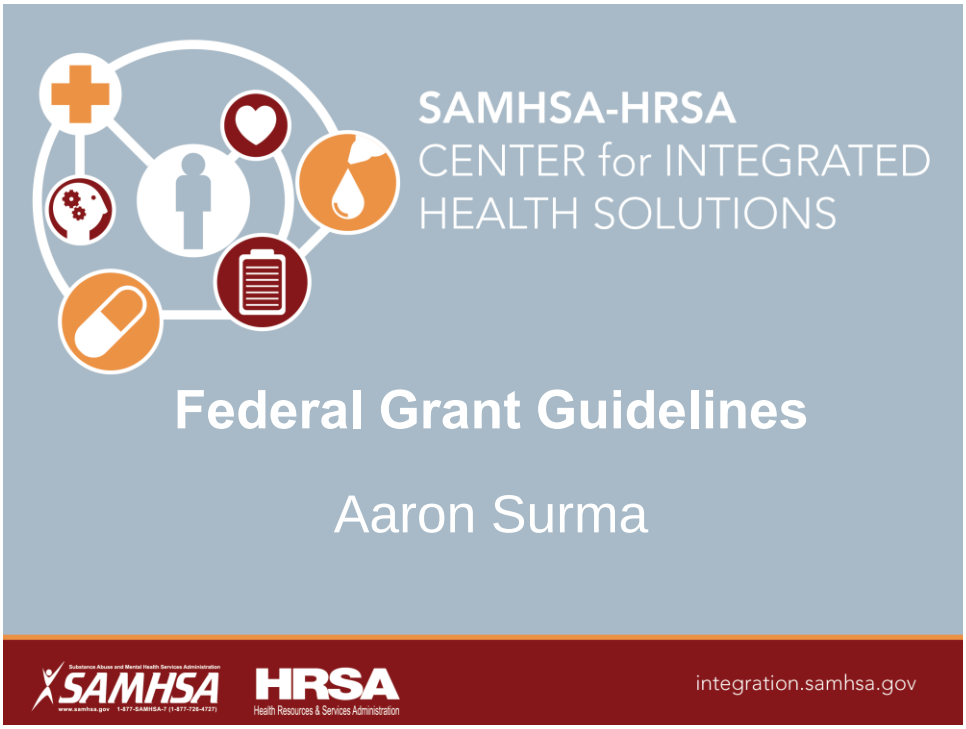
Agenda

- Welcome & Introductions
- Overview of discharge grant requirements
- Grantee perspectives on their discharge process and ensuring coordination and continuity of care
- Q & A

Learning Objectives

Participants will be able to:

- Identify criteria used to inform discharge planning
- Describe the discharge process, including attention to coordination and continuity of care
- Discuss effective data collection and utilization mechanisms used to inform administrative and clinical decisions



Conceptualizing Discharge from PBHCI

Discharge is from the grant, not your organization

Individuals can be re-enrolled in the grant after being discharged

Discharge should result from lack of contact, not from consumer's refusal to participate in NOMs or H indicators

PBHCI Discharge Guidelines

Data collection considerations

- Collect full interview & H indicators at discharge, regardless of when last reassessment occurred.
- If full interview is not possible, enter administrative interview information.

Timing considerations

- Discharge occurs immediately if the individual moves, passes away, is incarcerated, or is otherwise physically unavailable.
- Discharge is advised after 90 days without contact with the consumer and no expectation of future contact.

PBHCI Discharge Data

There are no official thresholds for % of consumers who are discharged or % of discharges with a full interview.

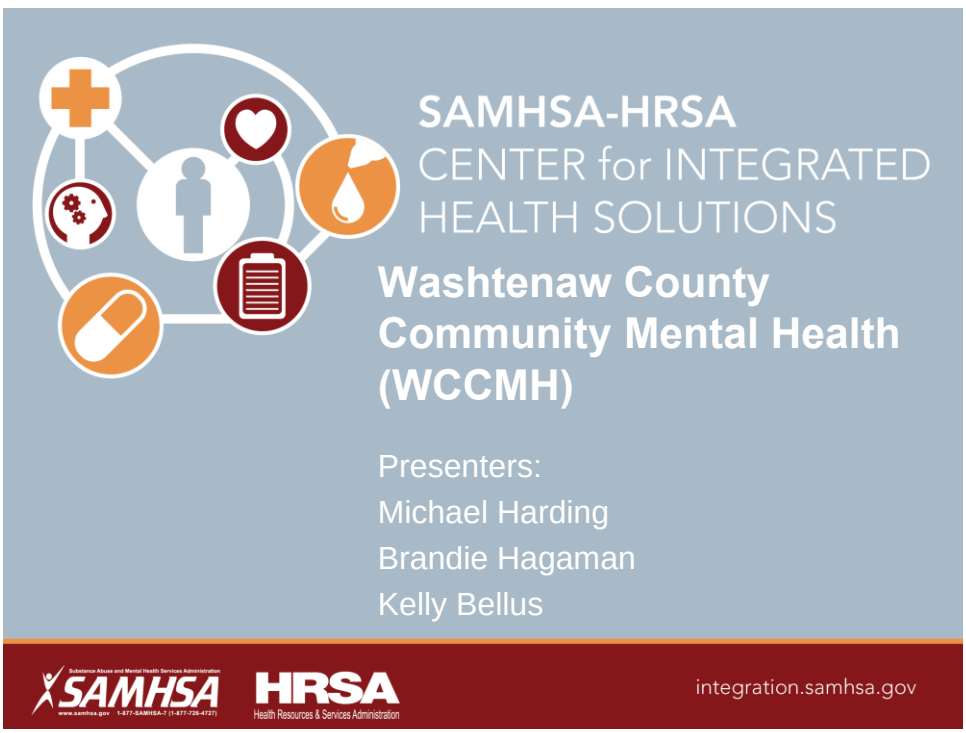
100% of grantees have discharged at least one person.

45% of grantees have performed at least one complete interview at discharge.

Discharge Process

Identify individuals who are eligible for discharge

- Prompt #1: As soon as you know someone is moving/ leaving services, schedule final NOMs & H indicators
- Prompt #2: When reviewing upcoming reassessments, identify individuals who haven't been seen at org in 90+ days
- Prompt #3: Use SPARS 'notification' report to identify individuals who have no activity in SPARS in 270+ days and who may be eligible for discharge



Objectives

- WCCMH Overview
- Discharge Criteria
- Coordination of Care Process
- Technical Overview

Washtenaw County CMH

- Primary behavioral health safety net provider for individuals with serious mental illness, intellectual/developmental disability, or serious emotional disturbance
- Provides mental health services to more than 5,000 patients
- Eligibility prioritizes Medicaid, no insurance, urgent or emergent needs
- Clinical Case Management – Leadership facilitation, assessment, coordination & monitoring of supports and services
- Washtenaw has been providing integrated care for 15+ years

WCCMH Discharge Criteria

- Review:
  - Insurance
  - Service Utilization
  - LOCUS Levels of Care
- Excluded individuals in level 3,4,5 or on Court Orders or Injectable Medications

LOCUS Level	Service
One	Meds Only / 1 - 2 CSM Contacts per year
Two	Less than 11 CSM Contacts per year
Three	Monthly CSM Contacts
Four	ACT
Five	Residential

270 individuals discharged in 2015

Coordination of Care Process

WCCMH Case Manager/Nurse contacts PCP Care Manager for case to be reviewed by PCP.

- Ensure consent is in place

Coordination of Care Process

If agreeable, WCCMH would notify provider that the most recent documentation is available in the HIE:

- Medication Review
- Diagnosis
- Current Medications
- Current Demographics for Consumer
- Current Health Assessment Document

Coordination of Care Process

WCCMH case manager will make PCP appointment with patient or have consumer tell them when appointment is and put a note in E.II.

- Contact PCP case manager who will add a coordination of care note into their EMR which lists the transfer and current meds/doses.

Coordination of Care Process

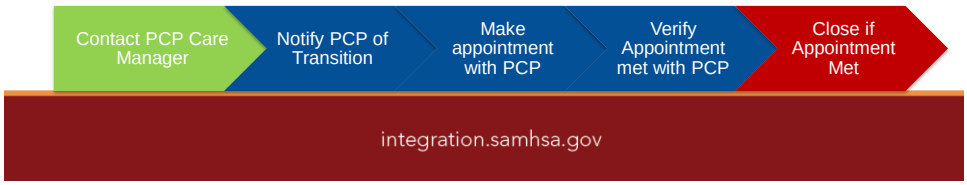
WCCMH case manager will then verify with provider if consumer attended appointment.

Coordination of Care Process

Once consumer has attended appointment then WCCMH will close them.

- WCCMH will be available to consult if needed.

If consumer did not attend appointment then process starts over until coordination of care happens.



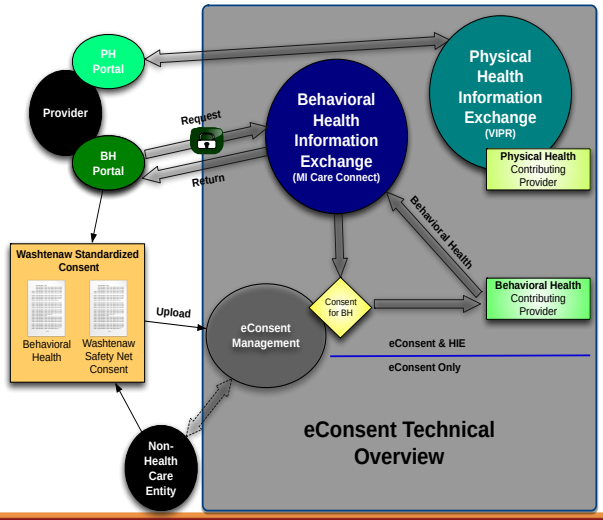
Continuity of Care Bracelets

Patients are the transporter of basic health information

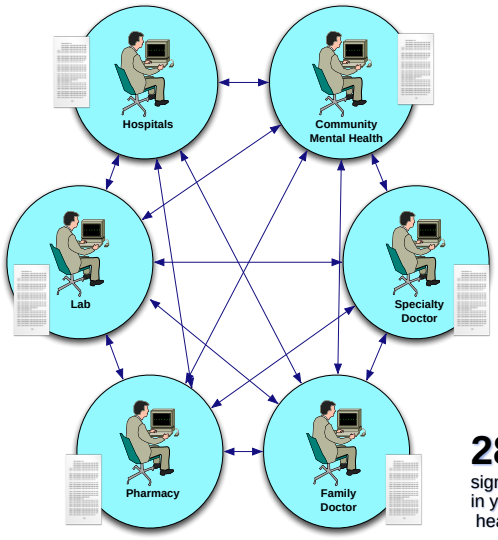
Lessons Learned:
- Health providers were not trained on downloading CCD
- Patients would not update info at every visit
- Patients would wear for a few days then stop wearing

Demographics
Diagnosis
Medications
Allergies
Emergency Contact

Technical Overview



Fragmented Consent Process

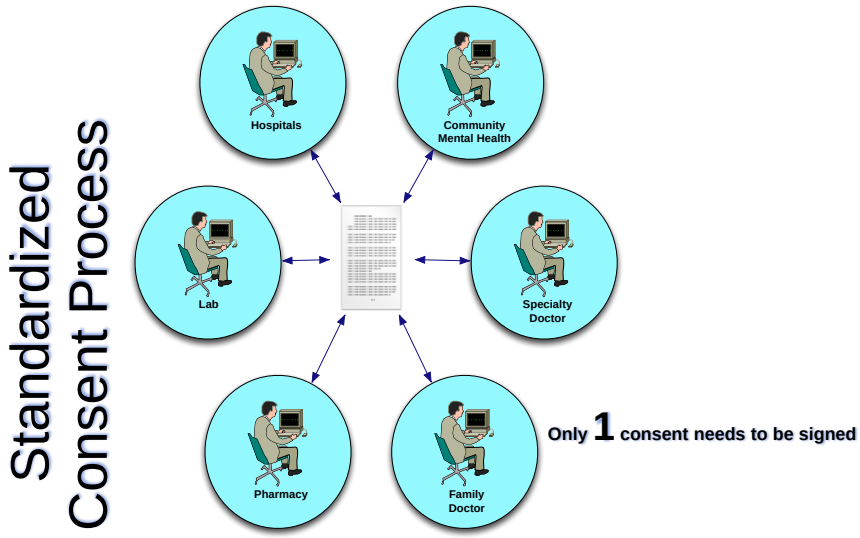


28 Consents need to be signed for providers involved in your care to see all your health information

Multi-Party Consent Process

I. **I consent to share my information among:**

1. Community Mental Health Partnership of Southeast Michigan
2. University of Michigan Health System
3. Saint Joseph Health System
4. Avalon Housing, Inc
5. Ann Arbor Housing Commissiion
6. Huron Valley Ambulance
7. Packard Health
8. _____
9. _____
10. _____



HIE Overview

Washtenaw CMH View of **Physical Health** Information

- GLHC Portal through the use of Single Sign On (SSO)
- Lab results feed directly into WCCMH EHR
- ADT's feed directly into WCCMH EHR

Community Partners View of **Behavioral Health** Information

- PCE Portal through MI Care Connect
- eConsent Management through MI Care Connect
- Integration with WCCMH EHR

Behavioral Data Available to Physicians

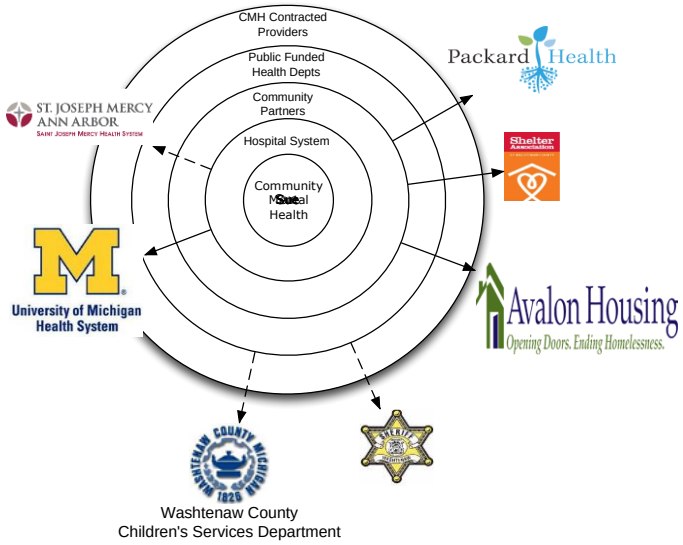
- eConsent
- Care Team
- Treatment Plans
- Appointments
- Problem Lists
- Medications
- Vitals
- Labs
- Clinical Forms
  - Med Reviews
  - Emergency Notes
  - Assessments, etc.

Physical Health Data Available via HIE

- Labs (Direct feed into Washtenaw EHR)
- ADT (Direct Feed from MIHN)

- VIPR (SSO into portal)
  - Care Team
  - Problem Lists
  - Past Medical History
  - Past Surgical History
  - Family Medical History
  - Social History
  - Vitals
  - Medications
  - Clinical Documentation

Integrated System of Care



WCCMH Vision to Integrated Care

- One unified and integrated system of health care and social services
- Providers involved in one's care have access to all relevant information in real time
- Enhanced consumer engagement and activation through technology

Wallowa Valley Center for Wellness

- Located in Enterprise, Oregon
- Frontier county
- Geographically isolated
- Non-profit
- 4th largest employer in Wallowa County
- Currently integrating with a local FQHC
- Recently started Oregon's first mobile mental health clinic with providers from our partner FQHC joining us

Consumer Stories

Discharge and transition success

Transition and reenrollment success

Discharge Criteria

- Consumer and ACT team mutually agree to termination of services
- Consumer moves out of service area
- Consumer declines or refuses services
- Long-term incarceration
- Long-term hospitalization
- Long-term residential stays
- Death

Transition to Less Intensive Services

- ACT team meets daily and discusses consumer level of engagement, need, and current progress toward goals
- Consumer meets criteria and agrees with transition to less intensive services
- Services are gradually scaled back without significant relapse for at least 12 months
- Once services are scaled back, consumer status monitored for 90 days
- Consumer can re-enroll for ACT level of care if needed and criteria met

Risk Assessment & Follow-Up

Risk of:

- Psychiatric hospitalization, admission to an acute/sub-acute facility, or use of psychiatric emergency services
- Hospitalization or an emergency room visit as a result of substance abuse
- An arrest or other law enforcement contact
- Homelessness or housing instability

Follow-Up:

- At least weekly contact for 90 days
- PCA coordination
- Coordination with PCP and/or other agencies

Q & A